MONTANA DPHHS EDI SUBMITTER ENROLLMENT FORM

Please return to:
ACS-Inc
ATTN: MT EDI
PO Box 4936
Helena, MT 59604
Or fax to 406-442-4402

EDI SUBMITTER ENROLLMENT FORM. Please print or type. Complete all areas of the Submitter Enrollment Form, unless otherwise indicated.

Section 1. Classification. Please indicate your classification.

☐ Software Vendor ☐ Billing Agent ☐ Clearinghouse

Section 2. Submission Method – Please indicate how you plan to submit your electronic transactions.

☐ Asynchronous (Direct Submission to EDI) ☐ WINASAP2003

Section 3 Submitter Information.

Business Name (If applicable)	
Submitter Name (Last, First, MI, and Suffix)	
Business Street Address	
City, State, and Zip Code	
Telephone	*Fax*
Email Address	*Federal Tax ID Number*

Section 4. Montana Submitter ID.

If you are currently submitting electronic transactions directly to Montana FAS, please indicate your Montana 7-digit Submitter ID: **NOTE: This is your Montana DPHHS Submitter ID Assigned by FAS**	☐☐☐☐☐☐☐

Section 4a. Submitter/Trading Partner ID Number.

If you are currently submitting electronic transactions directly to ACS EDI Gateway, please indicate your ACS EDI Gateway 5-digit Submitter ID or 6-digit Trading Partner ID: **NOTE: This is NOT your Montana submitter ID**	☐☐☐☐☐☐

Section 5. Software Vendors Only.

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If you have indicated that you are a Software Vendor in section 1, please provide the following information:					
Software Name:		Software Version:		Protocol:	
Do you currently have clients submitting to ACS EDI Gateway? ☐ Yes ☐ No					

Section 6. Contact Information. Please indicate contact information.

Contact Name	*Contact Title*
Business Street Address	
City, State, and Zip Code	
Telephone	*Fax*
Email Address	

Additional Contact Information. Please indicate additional contact information.

Contact Name	*Contact Title*
Business Street Address	
City, State, and Zip Code	
Telephone	*Fax*
Email Address	

Please attach additional sheets if necessary.

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Section 7. Transactions Available for Transmission.

Sub-Section 7a. WINASAP2003 (replacing ACE$ software).

Request for free WINASAP2003 Software:

☐ I will download a copy from the ACS website at http://www.acs-gcro.com/Medicaid_Accounts/Montana/montana.htm

☐ Please mail me a CD-ROM of the WINASAP2003 software

☐ X12N 837P (Professional Claim)	☐ X12N 837D (Dental Claim)	☐ X12N 837I (Institutional Claim)

Sub-Section 7b. Standard Transactions – Check all that apply (Submissions other than WINASAP2003).

☐ X12N 837P (Professional Claim)	☐ X12N 837D (Dental Claim)	☐ X12N 837I (Institutional Claim)
☐ X12N 276 (Claim Status Inquiry)	☐ X12N 270 (Eligibility Inquiry))	☐ X12N 278 (Prior Authorization)

Section 8. Delimiter Information.

If you are submitting X12N transactions directly to ACS, please provide the following information. **(This information is not required if you are using WINASAP2003)**

Element Delimiter to be used: ☐	**Segment Delimiter to be used:** ☐	**Sub-Element Delimiter to be used:** ☐
Default Delimiter (asterisk) *	*Default Delimiter (tilde)* ~	*Default Delimiter (colon)* :

Section 9. Electronic Response Retrieval.

Montana Submitters can retrieve their electronic responses from Host Data Exchange (HDE). If you would like to participate in this service, please complete the section below. For more detailed information regarding electronic remittance advices, please see the 835 Companion Guide located on the ACS website at http://www.acs-gcro.com/_Accounts/Montana/montana.htm

Responses available for X12N Transactions – check all that apply.

☐ X12N 997 (Functional Acknowledgement)	☐ X12N 835 (Healthcare Claim Payment/Advice)
☐ X12N 271 (Eligibility Response)	☐ X12N 277 (Claims Status Response)
☐ X12N 278 (Prior Authorization Response)	☐ X12N 824 (Error Response)
☐ Exception Report (Print Images) If you have selected this option you must complete the Business Associate Agreement (BAA). Please call 1.800.987.6719 to request the BAA be faxed or mailed to you or go to http://www.acsgcro.com/Medicaid_Accounts/Montana/EDI_Enrollment/edi_enrollment.htm and download the form. You may fax or mail this form to ACS EDI Gateway at the address or fax number below.	

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Provider Billing Agent/Clearinghouse ACS EDI Gateway, Inc Authorization Form

Section A. Provider Information.	
Business Name	
Provider Name (Last, First, MI and Suffix)	
Provider Number	*Federal Tax ID Number*
Business Address	
City, State, and Zip	
Telephone Number	*Fax Number*
Contact Name	*E-mail Address*

Section B. Authorization Signature *(required).*

Provider, _____ hereby appoints
Provider name /Provider Representative name (please print)

_____, _____
Billing Agent/Clearinghouse name (please print) *Billing Agent/Clearinghouse ACS Trading Partner/Submitter ID*

to act as the authorized agent for the purpose of submitting health care transactions electronically to ACS EDI Gateway, Inc. Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected below:

- ☐ 277-Claims Status Response
- ☐ 271-Eligibility Response
- ☐ 824-Error Report
- ☐ 835-Healthcare Claims Payment Advice
- ☐ 278-Prior Authorization Response
- ☐ 997 Functional Acknowledgement
- ☐ Exception Report

_____
Provider/Provider Representative name (Please print)

_____ _____
Provider/Provider Representative Signature *Date*